

**Oregon Coordinated Care Organizations'
Medicare-Medicaid / Dual Eligible
Assessment and Action Tool**



Division of Medical Assistance Programs
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What is Duals Alignment & How Do We Get There?



The journey of a thousand miles begins with a single step. —Lao Tzu

GOALS

Overarching Goals

The Oregon Health Authority (OHA) is providing this tool to assist with Oregon's health system transformation work, with specific focus on the health and quality of life of Oregon's "dual eligible" members (those who are eligible for both Medicare and Medicaid).

The overarching goals of this tool is to leverage Oregon's coordinated care model (CCM) to create additional opportunities to address alignment for dually enrolled Oregonians.

Dual alignment includes a focus on care coordination strategies, improved care transitions, improved member engagement and communication, administrative policy approaches, addressing health equity, health promotion and use of population health management tools which ultimately assist in meeting Oregon's Triple Aim of better health and better care at lower costs.

Goals applicable to Oregon's State Innovation Model (SIM) Grant

1. Spread elements of Oregon's coordinated care model

- a. Improve Medicaid/Medicare Alignment to improve care coordination through Health System Transformation, including patient centered primary care homes by January 2016.
- b. Address Medicare-Medicaid administrative alignments and quality improvements, delivery system reforms, and address shared accountability for Medicare-Medicaid, long-term care and CCO-LTSS alignment activities.
- c. Develop communications to increase member awareness of benefits of managed care/coordinated care.

- d. Expand CCO care coordination model to Medicare to meet improved care coordination goals through enhanced Medicare-Medicaid affiliations.

2. Reduce per-member per-month trend for duals by 1 percentage point by 2016 *

Other Goals

It may be possible to match areas of the tool to existing CCO goals and strategies through current transformation plans or LTSS-CCO memorandums and goals set to areas on the tool.



(*Oregon State Innovation Model Operational Plan)

THE TOOL – PURPOSE & VALUE

About the Tool

This tool is meant to assist you in review of CCO and community approaches to serving dual eligible members. This tool is meant for CCO's use in identifying opportunities to address dual eligible populations and sub-populations by providing a menu of best practice ideas that might be of value to your CCO.

This tool is not a report. It does not have a due date. As with other work currently underway in Oregon, taking a look at your duals approaches and current methods could provide opportunities that might not otherwise be easily identified to improve approaches that specifically address duals care coordination, engagement and communication among other areas covered by this tool.

We highly recommend starting with sections of the self-assessment checklist and reviewing with teams in internal meetings at the CCO. How are you doing at specifically adapting work to meet unique needs of dual eligible members? The tool can help you record your current status on work, identify priority areas you want to focus on, and later on see how your organization is moving forward on dual member alignment.

The list of strategies is vast, with some taking more planning, effort and resources, while others may just not have been things you have consciously addressed during your CCO start-up process.

The resource section also will point you in the direction of evidenced-based examples that may be of value to review as you make decisions on how to address gaps and needs.

How to Use This Tool

We have gathered best practice strategies into one document to create a simple process to identify alignment opportunities. This is a tool designed for Oregon CCOs and partners to examine their current practice for dual eligible members and to identify

opportunities to target strategies which can streamline communication and system challenges, meet quality of care goals, and monitor progress at achieving population specific targets.

This tool is meant to bring together the best of current knowledge and advice on integration for dual eligible members to improve health outcomes, quality of life, and member satisfaction in a format you can use at your local/regional level.

Under each focus section, a series of key strategies listed as best practice sub-topics and examples illustrate items to be considered in assessing your current processes and opportunities to address system barriers or challenges for dual members.

The tool allows for self-assessment of current status and goal-setting. While Oregon is on the forefront of best practices, we have combed through a full range of documents to pull together the items we have included in this tool which include both Oregon and outside of Oregon examples. We have also left you space to add additional innovative approaches you are putting in place to serve duals within your CCO or in partnership with your community and providers, since we know that Oregon CCOs are developing unique approaches that may prove to be best practices to share with other's nationally down the road.

The tool also points out some places where use of rapid cycle process improvement (PDCA) may help you monitor and take action on areas where you aren't sure how things are happening (i.e. are member referrals to community programs happening?).

The areas of focus on the tool: Communication, Population Health Management, Care Coordination, Care Transitions, Health Promotion, Engagement, Health Equity, and Administrative Policy Approaches and Leadership. Strategies and methodologies listed here may also be helpful for general care coordination and CCO work to reduce health disparities and meet Triple Aim goals.

Suggestions around adopting or monitoring quality and metrics in areas around care coordination, care transitions or population health management are topics which may need to be discussed in more detail in quality and measurement forums, or within your own CCO data management teams.

The tool has best practice ideas that are likely to connect with work you are hoping to achieve this year through your new CCO-LTSS MOUs or your transformation plans.

Some of the items are easier to put in place than others which might take a bigger lift, such as building IT system supports to make data sharing happen in a way that best supports your work for dual eligible members. We have included a wide variety of practices collected from national materials, so some may be more aspirational than practical given current status and plan priorities.

Communication tools suggested here may also require Medicare or State Medicaid review as part of your CCO adoption process, so please be aware that this tool does not change communication approvals process.

CMS Alignment will be a meeting where CCOs can continue to work with the State to look at ways to improve alignment for dual eligibles through communications. Ideally, we have provided you with topics and best practice strategies that will assist you in moving toward your existing goals as a coordinated care organization while also specifically identifying challenge areas around dual Medicare-Medicaid members you serve.

Important Tool Sections

Please note the Self-Assessment Checklist and Blank Planning Tool, as well as the list of references by topic area included in this document.

Tool Focus Areas

We have chosen several areas for you to look at duals alignment approaches within your CCO and community, many of which may connect with other

work you are already focused on to address performance or outcome measures or improvements to customer service for members.

The eight areas of focus included in the tool are: Communication, Population Health Management, Care Coordination, Care Transitions, Health Promotion, Engagement, Health Equity and Administrative Policy Approaches/Leadership.

The Executive Summary will highlight these 8 areas and best practice sub-topics. Additional best practice examples will be provided later in this document and can be used as a full checklist to go through to choose areas you are interested in addressing to improve alignment and customer service for dual eligible members.

We also provide a blank copy of the tool for you to create your own targeted work plan and focus for your team's chosen focus. The goal is for each CCO to use this information in a way that works best – this could be through an internal plan workgroup, or through meetings with your CAC or LTSS or affiliated Medicare plans.

How Do We Use this Tool for Assessment of Current Status?

The checklist portion of this tool will allow you to walk through each area and review a number of best practices to see which ones you might already be doing, as well as which you might want to focus on in the next few years. OHA TA support is available as noted in this document to be available to support you in this process and is customizable to your desired process.

Periodically repeating the assessment portion of the tool can assist you in tracking changes being implemented. You will probably prefer to take a small bite of the tool in particular areas rather than trying to work through it all at once. You might decide certain sections are better for your care coordination staff to take the lead working through and reporting back on, or would be best working through in concert with your community advisory council. You may also decide that your internal

leadership will walk through various sections of the tool in a series of meetings over several months, and development of prioritization and action planning will come once you fully have a sense of what is in place, then reviewing what might be best places for action.

Remember that technical assistance is available to you to work through these processes and consider your options for how you will use the tool, what might be the best way to engage staff with the tool, and assistance with prioritization and action planning meetings. So please do not hesitate to engage our TA support!

How Do We Use this Tool for Documenting Progress Toward Selected Goals?

The blank form provided for you at the end of this document allows you to select areas for focus, best practice strategies being chosen, set timelines for completion, and come back for progress checks at selected intervals.

For focus areas chosen, the tool can serve as a progress report on goals at self-determined intervals. At a minimum, we would suggest an annual evaluation of progress. Document your progress over multiple years by reviewing increased percentage of items addressed.

TECHNICAL ASSISTANCE

Contact for SIM Funded Technical Assistance

Technical assistance will be available for CCOs from OHA's Medical Assistance Program's Medicare-Medicaid Operations and Policy Analyst Jennifer Valentine.

Jennifer will be able to schedule visits to individual CCOs to assist with working through the tool. If you have any questions about using the tool, what type of process might work best for your unique setting, or to ask for OHA support with meetings to review the tool, take on action planning, or have any other questions, do not hesitate to request consultation and support.

To request a technical assistance visit or team meeting facilitation for CCO and partner conversation around this tool, please contact Jennifer Valentine, with the Division of Medical Assistance Programs at the Oregon Health Authority. Jennifer can be reached at 503-945-6800 or Jennifer.B.Valentine@state.or.us.



KEY FOCUS AREAS & BEST PRACTICE SUB-TOPICS

Communication

- C1. Adopt integrated communications for duals
- C2. Adopt communication best practices to improve health literacy and member engagement
- C3. Establish communication protocols for information sharing across CCO-MA/SNP plans and/or CCO-LTSS to improve care coordination for dual eligible members
- C4. Support development of protocols and training for front-line communications staff to improve communication to dual eligible members
- C5. Monitor improvements in customer satisfaction with communication
- C6. Ensure providers are fully aware of CCO work to improve duals care coordination, billing issues, and reduce administrative burdens.
- C7. Develop communication channels with stakeholders around service delivery system improvements to address the diverse needs of all plan enrollees



Population Health Management

- PHM1. Plan Level Population Health Monitoring
- PHM2. Support Provider Practice Level Population Health Monitoring
- PHM3. Utilize clinical data to monitor population health
- PHM4. Monitor outcome and quality measures



Care Coordination

- CC1. Identify and prioritize high needs members
- CC2. Develop Individualized Care Plans
- CC3. Engage primary care homes in care coordination where applicable with supports from CCO
- CC4. Plan for Care Transitions process
- CC5. Engage Individuals, Caregivers, and Identify preferences
- CC6. Establish and Maintain Care Teams through a locally-driven, collaborative process, ensuring team membership meets regularly to address care needs of individual members

- CC7. Engage LTSS Innovator Agents to help work through challenges or to engage targeted planning and conversations between CCO and LTSS, DD and senior advocate partners
- CC8. Monitor Care Teams and document care coordination improvements/outcomes
- CC9. Establish provider and care coordination role relationships and regular interactions process
- CC10. Promote provider relationship building across care domains by encouraging primary care, LTSS and behavioral health to co-participate in learning collaboratives and care conferences for complex care patients.
- CC11. Promote care team continuing education concerns around specific geriatric and disability health needs (i.e. education on how to assess for cognition, manage dementia, assess for falls, engage family/friend caregivers, assess need for social support and interactions, etc.)

ACA Definition of Person-Centered Planning

Person-centered planning is a process directed by the person with LTSS needs. It may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person.

The PCP should also include family members, legal guardians, friends, caregivers, and others the person or his/her representative wishes to include.

The PCP should involve the individuals receiving services and supports to the maximum extent possible, even if the person has a legal representative.

The PCP approach identifies the person’s strengths, goals, preferences, needs (medical and HCBS), and desired outcomes. The role of agency workers (e.g., options counselors, support brokers, social workers and others) in the PCP process is to enable and assist people to identify and access a unique mix of

paid and unpaid services to meet their needs and provide support during planning. The person’s goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, family relationships, and treatments are part of a written plan that is consistent with the person’s needs and desires.

Preferences may include, for example, the following concepts related to the person’s experience and necessary supports:

- Family and friends • Housing • Employment • Community integration • Behavioral health • Culture • Social activities • Recreation • Vocational training • Relationships • Language and health literacy • Other community living choices

The PCP assists the person to construct and articulate a vision for the future, consider various paths, engage in decision-making and problem solving, monitor progress, and make needed adjustments to goals and HCBS in a timely manner. It highlights individual responsibility including taking appropriate risks (e.g. back-up staff, emergency planning). It also helps the team working with the individual to know the person better.



Care Transitions

- CT1. Adopt Evidence-based Care Transition Models/Initiate Care Transition Programs and policies to ensure positive care transitions

(effectively targeted for high-risk beneficiaries, ROI shows can be as high as 250%)

- CT2. Expand care transitions models to extend to address whole person health (i.e. innovative functional-and lifestyle-oriented programming beyond traditional health benefits covered by health care)
- CT3. Engage traditional health workers such as patient navigators, peer wellness counselors or community health workers to support transitional needs
- CT4. Create communication and technology mechanisms to share patient needs with multiple provider teams that include primary care, LTSS, behavioral health, community-based services, and others as identified for specific patient care needs
- CT5. Designing systems and processes to rapidly and effectively respond to changes in patient conditions[especially to avoid use of unnecessary services, particularly emergency department visits or hospitalizations, ensuring all partners receive needed communication to respond]

Health Promotion (including Chronic Disease Management)

- HP1. Create effective referral and feedback loops to ADRC or Public Health Evidence-Based Health Promotion Programs
- HP2. Promote chronic disease self-management skills and self-care efficacy (i.e. such as patient/family centered simulations for home care skills) for all dual eligible clients with at least one chronic condition
- HP3. Utilize pro-active health risk assessments that include social, home, community supports and functional health status to tailor medical and non-medical supports and care supports

HP4. Work closely with your CCO's community advisory council(s), ADRC, and local non-profits regarding access to community-based health promotion programs for dual eligible members

Engagement

- E1. Adopt strategies to reach members, including homeless and "hard-to-reach" members
- E2. Engage member and family/caregiver in care conferences and care planning
- E3. Develop Strong member outreach mechanisms, consumer friendly member services (e.g., call systems), and provide patient navigators, advocates, ombudsmen to support and assist clients



Health Equity

- HE1. Identify and recognize cultural practices and beliefs that impact care planning and member preferences
- HE2. Ensure member access to information/materials through use of trained interpreters, translated materials, materials with appropriate health literacy levels, and alternative formats as necessary
- HE3. Promote care team continuing education concern around best practice methods to

SECTION B: Tools for Coordinated Care Organizations

SELF-ASSESSMENT CHECKLIST

Review duals best practices within your CCO and community

CCO BLANK PLANNING FORM

Target areas and select strategies, Set Goal Timelines, Monitor Progress toward Goals

SECTION C: References & Resources

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